

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
LED MAY 27 1946
Registration District No. **318**

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

18836
State File No. _____
Registrar's No. **4500**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4119 Beethoven
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4119 Beethoven**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **August Koeder**
(b) If veteran, name war _____
(c) Social Security No. **497-16-6724**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **19**
year **1946** hour **3** minute **30P** M.
21. I hereby certify that I attended the deceased from _____
_____ 19____ to _____ 19____
and that death occurred on the date and hour stated above.

4. Sex **Male** (1) 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ethel**
6. (c) Age of husband or wife if alive **49** years
7. Birth date of deceased: **May 28 1898**
(Month) (Day) (Year)

Immediate cause of death
Cerebral apoplexy
Duration **Sudden**
Due to **My peritonsillar abscess, ruptured Chr. tubercle**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: **none**
Of operations _____
Of autopsy _____

8. AGE: Years **47** Months **11** Days **21**
If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Mgr. Safe Deposit Dept. Mercantile-Commerce Bank**

11. Industry or business _____

MOTHER FATHER { 12. Name **Carl Koega**
13. Birthplace **Unknown Austria**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown Msqua**
(City, town, or county) (State or foreign country)

15. Birthplace **Unknown Austria**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ethel L. Roeder**
(b) Address **4119 Beethoven**

17. (a) **Burial** (b) Date thereof **5/23/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Wacker-Waldick**
(b) Address **3634 Gravois Ave.**

19. (a) **MAY 20 1946** (b) **J. F. Benedek**
(Date received local registrar) (Registrar's Signature)

Physician
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Paul Brown** (M. D. or other) _____
Address **Paul Brown, Bed** Date signed **May 20**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Robert Wheeler

Licensed Embalmer No. 2178

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.